

Illinois Department of Public Aid

MCH Primary Care Provider Agreement

PROVIDER INFORMATION

Name <i>Last</i> <i>First</i> M.I.	Provider #	License #	
Office Address	City	State	Zip
Office Phone ()	After Hours Phone	FAX	

My Specialties Include: (check all those that apply)

<input type="checkbox"/>	OB/GYN	<input type="checkbox"/>	Internist
<input type="checkbox"/>	Pediatrics	<input type="checkbox"/>	General Practice
<input type="checkbox"/>	Family Practice	<input type="checkbox"/>	Other (specify)

I Hold Hospital Admitting Privileges at the Following Hospitals:

Hospital Name	Hospital Address	Delivery Privileges yes no	IDPA Use Only

My Other Practice Locations Include:

Physician or Clinic Name	Street Address/City/Zip	Phone

Certification:

I certify that I meet the participation requirements of an MCH Primary Care Provider, as cited in Section B of the reverse page. I also understand that I must notify the Department in writing should any changes to the information contained herein become necessary. I also understand that the information I enter on this form will be used to update the Department's data base.

Provider Signature

Date

Mailing Instructions:

Please mail your original signed copy to:

Provider Participation Unit
P. O. Box 19114
Springfield, Illinois 62794-9114

Illinois Department of Public Aid

MCH Primary Care Provider Agreement

This Agreement pertains only to the relationship of the Illinois Department of Public Aid with the Provider under the Department's MCH (**Maternal and Child Health**) Program. This Agreement does not affect any other relationship or agreement, including but not limited to, the general Provider Agreement, between the Department and the Provider.

Section A: Department Responsibilities

In partnership with the Physician named herein, the Department agrees to:

- o pay enhanced rates for prenatal risk assessment, which includes substance abuse information;
- o pay enhanced rates for delivery services;
- o pay enhanced rates for primary care office visits and screening services provided to children;
- o provide expedited processing of claims for physicians who meet established criteria and request special processing;
- o upon request, furnish client eligibility and profiles of prior services reimbursed by the Department;
- o provide support services as needed for the purpose of client follow-through on treatment regimen;
- o facilitate access to medical care for clients in cooperation with the case manager through the local health department, community-based organization or certified clinic.

Section B: Participation Requirements

As a participant in the MCH Program, I agree to:

- o maintain hospital admitting privileges;
- o provide periodic health screenings (EPSDT) and primary pediatric care as needed;
- o provide obstetrical care, delivery services, as appropriate;
- o perform risk assessment for pregnant women and/or children;
- o maintain 24-hour telephone coverage for consultation including ensuring that "sick" children and "at-risk" pregnant women are treated as needed, based on triage of need;
- o schedule diagnostic consultation and specialty visits or contact the designated case management entity to coordinate/schedule the visit as appropriate;
- o provide adequate equal access to medical care for clients in cooperation with the Department or its designated case management entity;
- o communicate with case management entity.

Special Provisions:

You may terminate your participation as a Primary Care Provider in the MCH Program upon forty-five days written notice sent by certified mail to the:

Provider Participation Unit
P. O. Box 19114
Springfield, Illinois 62794-9114

The Department may terminate a Provider's participation as a Primary Care Provider in the MCH Program under this Agreement if the Provider fails to maintain any of the above participation requirements, or for other cause, upon forty-five days written notice. Such termination shall not be subject to the Department's rules and regulations on notice and hearing for a Provider's termination from participation in the Medical Assistance Program.